



# **Department of Veterans Affairs Office of Inspector General**

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## **Healthcare Inspection Alleged Quality of Care and Staffing Issues VA Western New York Healthcare System Buffalo, New York**

**To Report Suspected Wrongdoing in VA Programs and Operations:**

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## Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant concerning quality of care and physician staffing in the Emergency Department (ED) of the VA Western New York Healthcare System, Buffalo, NY (the facility).

We substantiated the allegation that two patients did not receive adequate evaluation and management in the ED, resulting in delayed treatment. The same physician evaluated both patients on their initial visits to the ED, and both patients returned to the ED and required admission for treatment. The services provided to these patients on their initial visits did not meet Veterans Health Administration (VHA) policy and clinical standards, and the physician's documentation for the initial visits did not meet VHA standards. We did not substantiate quality of care concerns for a third patient. Facility managers had previously identified quality of care concerns with the physician who initially treated the three patients in the ED, yet they had not taken appropriate corrective actions in response to these concerns, as required by VHA policy.

We substantiated the allegation that the ED was understaffed since at least November 2010 and that physicians often worked excessive clinical hours. The short-staffing resulted in some questionable decisions by facility managers, including reappointing to the medical staff the physician noted above, with previously identified quality of care concerns, and temporarily assigning primary care physicians to the ED, including one who was not properly privileged.

We substantiated that the facility was on diversion overnight while two physicians were staffing the ED and inpatient beds were available. However, we were unable to identify any patients who were diverted to local hospitals.

To improve the quality of patient care and staffing in the ED, as well as to follow up on quality of care concerns raised in specific cases, we recommended that the interim facility Director: (1) consult with Regional Counsel regarding possible institutional disclosure to the families of the patients for whom quality of care concerns were identified, (2) consult with Regional Counsel regarding possible notification of quality of care concerns for a physician to the state licensing agency and/or National Practitioner Data Bank, (3) ensure facility staff comply with VHA policies on peer review and physician privileging, and (4) fully implement the May 2011 medical center policy addressing ED operations.

The Veterans Integrated Service Network and Interim Facility Directors concurred with the findings and recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.



**DEPARTMENT OF VETERANS AFFAIRS**  
**Office of Inspector General**  
**Washington, DC 20420**

**TO:** Interim Director, VA Western New York Healthcare System (528/00)

**SUBJECT:** Healthcare Inspection—Alleged Quality of Care and Staffing Issues,  
VA Western New York Healthcare System, Buffalo, New York

## **Purpose**

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant concerning quality of care and physician staffing in the Emergency Department (ED) of the VA Western New York Healthcare System, Buffalo, NY (the facility).

## **Background**

### **VA Western New York Healthcare System**

The facility is part of Veterans Integrated Service Network (VISN) 2 and comprises campuses in Buffalo and Batavia, NY. The Buffalo campus includes a 199-bed tertiary care facility and six community based outpatient clinics. The facility has acute medicine, surgical, psychiatric, and intensive care beds and is a referral center for cardiac surgery, cardiology, and cancer care. The ED has 12 beds and receives approximately 16,000 patient visits annually. Until May 2011, the ED also staffed a five-bed observation unit.

## **Allegations**

On April 26, 2011, the OIG's Hotline Division received an anonymous complaint regarding quality of care and physician staffing in the ED. Specifically, a complainant alleged that:

- The facility appointed an ED physician who was considered “unsafe,” and, following the physician’s first ED shift, three patients treated by this physician required return visits to the ED.
- The number of physicians has been insufficient to staff the ED since November 2010, resulting in “long shifts” and impacting patient care.

- During one night shift in April 2011, facility leaders kept the ED on full diversion despite there being two physicians on duty and inpatient beds available, resulting in an unnecessary patient diversion to another facility.

## Scope and Methodology

To address the allegations, we visited the facility June 20–23, 2011, and we interviewed facility leadership and selected ED providers and nursing staff. We reviewed the medical records of three patients who returned to the ED within 24 hours of treatment on the date identified in the complaint. Although we reviewed the medical records for compliance using VHA and industry standards for care and documentation, we did not determine whether the care was negligent as defined by state negligence standards. We also reviewed ED physician credentialing and privileging files, applicable facility reports, facility policies, Veterans Health Administration (VHA) policies, and applicable clinical standards and medical literature. We also interviewed the VHA National Director for Emergency Medicine.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of Inspectors General on Integrity and Efficiency.

## Case Summaries

**Patient 1.** The patient was a man in his eighties who presented at the ED at 12:22 a.m., with abdominal pain for a “couple of days” with a pain intensity score of 9 out of 10, with 10 being the worst pain. He described the pain as aching and said that nothing alleviated it.

The ED triage nurse recorded that the patient’s pulse was elevated and his blood pressure was normal. The temperature was not recorded. The nurse drew blood for laboratory tests, and the patient had chest and abdominal x-rays. According to the nursing progress notes, the patient slept until 3:45 a.m., when he spit up clear mucous with streaks of a brown colored secretion. The patient complained that his abdomen hurt and he felt he had not slept. The nurse documented that the ED physician was informed about the colored mucous and that the patient’s pulse remained elevated. At 4:50 a.m., the nurse gave discharge instructions to the patient’s family, including education on constipation medications and instructions to follow up with the patient’s primary care physician.

The physician’s note at 4:59 a.m. documented the patient’s presenting symptoms as heartburn, abdominal pain, belching/gas, nausea and vomiting, and constipation and that the patient was in no acute distress. The physician documented a normal examination of the patient’s heart and lungs but noted that his abdomen was distended, soft, and tender. The physician recorded that the patient’s x-rays and labs were “unremarkable” and that the patient’s condition was improved. The physician did not record the patient’s past medical history. The patient returned to the ED at 4:49 p.m. with dull aching abdominal

pain that scored 9 out of 10 for pain intensity. The patient received care from a different ED physician who noted that the patient's medical history included previous colon cancer surgery. The patient's pulse was elevated, his BP was normal, and he had a slight fever. He complained of dark emesis (vomiting) 10 times during the past 24 hours, which the physician documented as feculent.<sup>1</sup> The physician ordered a computerized tomography (CT)<sup>2</sup> scan and, after diagnosing a mechanical small bowel obstruction,<sup>3</sup> admitted the patient to the Intensive Care Unit (ICU) for treatment and surgical consultation.

According to the ICU patient record, the patient had a myocardial infarction (MI)<sup>4</sup> probably due to severe low blood pressure and elevated pulse. Because of the MI, he did not undergo surgical repair of the small bowel obstruction. The patient continued to deteriorate and died within 3 weeks.

**Patient 2.** The patient was a man in his seventies with advanced amyotrophic lateral sclerosis (ALS)<sup>5</sup> who had received care from the facility since 2006. He had three ED visits during the 3 months preceding this visit for symptoms of shortness of breath and inability to cough up secretions. On two of the three previous ED visits, providers drew arterial blood gases (ABGs)<sup>6</sup> to assess for respiratory acidosis.<sup>7</sup> Because of the respiratory muscle weakness due to his ALS, the patient used non-invasive positive pressure ventilation<sup>8</sup> at night.

On this visit, the patient presented to the ED with shortness of breath, inability to cough up phlegm, and abdominal discomfort. Nursing reported that his temperature and blood pressure were normal, but his respiratory rate was elevated. At 9:00 p.m., a nurse documented that she placed the patient on oxygen using a nasal cannula<sup>9</sup> and obtained blood samples for laboratory tests, which did not include an ABG. The patient had chest and abdominal x-rays and a nebulizer treatment for shortness of breath. At 2:00 a.m., the physician discharged the patient.

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<sup>1</sup> Feculent is used to describe material containing feces or other waste matter from the intestines.

<sup>2</sup> CT scans are a computer generated medical imaging method that combines a series of x-rays that produce a three dimensional image of patient's bones and soft tissues.

<sup>3</sup> A mechanical small bowel obstruction occurs when material or an object partially or completely blocks the small intestine preventing passage of feces.

<sup>4</sup> An MI occurs when blood flow to the patient's heart is interrupted due to either a medical complication or trauma, causing damage to the heart.

<sup>5</sup> ALS, also known as Lou Gehrig's Disease, is a neurological disease that causes muscle weakness, disability, and eventually death.

<sup>6</sup> An ABG is a blood test that uses blood from an artery to measures the acidic content of the blood as well as the amount of oxygen, carbon dioxide, and bicarbonate in the blood.

<sup>7</sup> Respiratory acidosis is a medical condition caused by a patient's respiratory decline that will eventually cause death due to abnormally low oxygen blood levels and abnormally high carbon dioxide levels. Patients with ALS are prone to respiratory acidosis because of muscle weakness.

<sup>8</sup> Non-invasive positive pressure ventilation is respiratory support given by providing air delivered under pressure through a face or nasal mask.

<sup>9</sup> A nasal cannula delivers oxygen passively (without force) to the patient through a tube with two prongs at the end that are placed in the patient's nostrils.

At 3:40 a.m., the physician documented that all laboratory tests and x-rays were unremarkable and that the patient's issues were mild sinusitis and dysphagia (difficulty swallowing). The physician did not document a complete physical examination but did address the patient's complaints. The physician also listed the patient's condition as improved.

The patient returned to the ED at 4:00 p.m. that same day complaining of shortness of breath and inability to cough for the past 2 weeks, and he saw a different ED physician. ABGs drawn at 6:06 p.m. were significantly abnormal, and the physician diagnosed respiratory acidosis. The patient was admitted to the ICU where he was placed on continuous non-invasive positive pressure ventilation. However, his condition deteriorated. The patient refused intubation (mechanical ventilation) and died within a few days.

**Patient 3.** At 6:25 p.m., during the same shift as the other two patients, a man in his eighties presented to the ED with chest and upper abdominal pain. His pain score was 6 out of 10, and he reported that nothing he tried at home alleviated the pain. The patient's temperature and blood pressure were normal, but his pulse and respirations were elevated. At 12:01 a.m. the next day the patient had a CT scan of the abdomen, and, based on the results indicating a probable abdominal aortic aneurysm (AAA),<sup>10</sup> the ED physician requested a vascular surgery consult.

After reviewing the CT scan and examining the patient, the vascular surgeon confirmed the diagnosis of AAA. The surgeon documented that the patient's pain had resolved and that his condition appeared stable. The patient requested to go home, and the ED physician discharged him with instructions to return to the ED if he had any symptoms of a ruptured aneurysm.<sup>11</sup> The patient returned to the ED later that day with increasing abdominal pain, and the vascular surgeon admitted the patient for an urgent AAA surgical repair. The patient recovered from surgery and was discharged.

## Inspection Results

### Issue 1: Quality of Care

We substantiated the allegation that Patients 1 and 2 did not receive adequate evaluation and management in the ED, resulting in delayed treatment. The ED care that Patients 1 and 2 received on their initial visits did not meet VHA policy and industry quality of care standards, and the physician's documentation for these initial visits did not meet VHA standards.

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<sup>10</sup> An AAA is a dilation of the aortic artery (artery that flows from the heart) causing a weakness in the artery wall which may rupture.

<sup>11</sup> Symptoms of a ruptured AAA include abdominal, back or leg pain, fainting or lightheadedness, nausea and vomiting, sweating, increased pulse, and confusion or loss of consciousness.

We did not substantiate the allegation that Patient 3 received inadequate treatment on his initial visit to the ED. The physician correctly diagnosed an AAA and ordered an urgent vascular surgery consult. After evaluating the patient, the vascular surgeon advised the patient to remain at the facility for further treatment, but the patient requested to leave.

**Inadequate Evaluation and Management.** The physician who initially treated Patients 1 and 2 did not use the most common and effective industry diagnostic tools. The wrong diagnoses and medical management delayed appropriate treatments for several hours and caused symptoms to worsen and become more complicated to treat.

**Patient 1.** Guidelines for initial evaluation of abdominal pain support a triage approach utilizing presenting symptoms, examination findings, and diagnostic assessments to identify those patients with a higher likelihood of a serious condition requiring immediate intervention.<sup>12</sup> The initial assessment should attempt to exclude the presence of a serious underlying disease, such as small bowel obstruction. Findings of fever, tachycardia, abdominal tenderness and distention, and advanced age are specific indicators of serious disease. When these signs are present, clinical guidelines recommend CT scanning if x-ray images are non-diagnostic.

The evaluation of Patient 1 on his initial ED visit was incomplete. The physician did not assess serial vital signs, including temperature; perform serial abdominal exams; or obtain further appropriate diagnostic imaging after the initial x-rays were non-diagnostic.

**Patient 2.** This patient had a documented history of respiratory compromise related to progression of his underlying neurologic disorder. On presentation to the ED with worsening shortness of breath, clinical guidelines for patients with this condition recommend a complete assessment of pulmonary status to exclude respiratory failure. The guidelines recommend obtaining an ABG to assess for an elevated carbon dioxide level as a possible underlying cause of respiratory acidosis.<sup>13</sup> If present, treatment of respiratory acidosis may require continuous non-invasive positive pressure ventilation or intubation with mechanical ventilation.

The evaluation of Patient 2 on his initial ED visit did not include an ABG to measure carbon dioxide levels. Not until later in the day, in a return ED visit, was an ABG ordered, a diagnosis of respiratory acidosis made, and appropriate treatment begun.

**Incomplete Documentation.** The physician's documentation of the initial visits for Patients 1 and 2 did not meet VHA standards. VHA policy requires that ED staff document specific items to support diagnostic and treatment decisions. Documentation

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<sup>12</sup> Medscape Reference, *Bowel Obstruction in Emergency Medicine*, updated November 2009, <http://emedicine.medscape.com/article/774140-workup#a0720>, accessed July 20, 2011.

<sup>13</sup> Medscape Reference, *Respiratory Acidosis*, <http://emedicine.medscape.com/article/301574-overview>, accessed July 21, 2011.



should include a history, including prior care; physical examination findings; an assessment of the problem, including indicated tests; the basis for ordering tests; a treatment plan, including any consultations; the patient's condition at the time of discharge; and discharge instructions. The ED provider is responsible for ensuring this documentation is complete and accurate.<sup>14</sup>

For Patients 1 and 2, there was insufficient documentation concerning past and present medical conditions. Documentation was incomplete regarding portions of the physical examinations and medical histories, with no reference to Patient 1's history of colon cancer, which increased his risk for bowel obstruction.<sup>15</sup> Documentation on Patient 2 included a list of previous diagnoses but no other history. The documentation also did not include any information regarding prior treatments or follow-up treatment plans for the two patients.

**Failure To Follow Peer Review Process.** Peer review is a non-punitive, confidential process used to evaluate care provided to patients by individual providers. According to VHA policy, the formal process of peer review involves evaluation of specific episodes of care, determination of necessary specific actions based on evaluations, confidential communication with providers, and identification of systems and process issues that may require special actions.<sup>16</sup> The facility's Peer Review Committee (PRC) is responsible for overseeing the process by designating peer reviewers and monitoring the completion of actions.<sup>17</sup> Our review of PRC minutes for 18 months showed no evidence that the PRC followed corrective actions to completion for *any* providers who had been peer reviewed with significant findings or that supervisors reported to the committee when peer review actions were completed.

## Issue 2: ED Physician Staffing

We substantiated the allegation that the ED was understaffed since at least November 2010. As a result, physicians often worked excessive clinical hours, and on several occasions, physician staffing in the ED fell below VHA recommended levels. Short staffing also resulted in some questionable appointment decisions by facility management.

**VHA Policy and ED Staffing Standards.** VHA requires that facility leadership adequately staff the ED with qualified providers and nurses and develop a local staffing policy to address the number of providers needed at all hours of operation. The policy

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<sup>14</sup> VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

<sup>15</sup> Richard A. Kamin, MD et al., *Pearls and Pitfalls in the Emergency Department Evaluation of Abdominal Pain*, Emergency Medicine Clinics of North America, 21 (2003) 61–72.

<sup>16</sup> VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008, and updated VHA Directive 2010-025, June 3, 2010.

<sup>17</sup> VHA Directive 2010-025.

should also provide contingency plans to augment ED staffing when the number of patient visits exceeds the ability of the available providers to provide safe care.<sup>18</sup>

The standard for provider staffing at VHA EDs requires that at least one physician be on duty 24 hours a day and that provider staffing be adjusted to match patient volume. Because of the complexity of many veterans' medical conditions, VHA recommends that facilities adjust ED staffing so that each physician sees two patients per hour.<sup>19</sup> During the hours when patient volume is likely to exceed this level, the ED director should schedule a second provider, either a physician or a mid-level provider (for example a nurse practitioner or physician's assistant). Facilities are required to monitor patient numbers to identify hours when the volume is likely to exceed two patients per hour.

At the time of the allegations, the facility's standards of operation for the ED did not address physician staffing or contingency planning. On May 19, 2011, the facility updated the standards to address physician staffing and contingency planning; however, the updated policy had not been fully implemented.<sup>20</sup>

**ED Staffing.** The facility's ED is approved for six physician full-time equivalents (FTE). For the first half of calendar year 2010, the department was staffed with five full-time VA physicians, with the remaining FTE filled by physicians paid on a fee basis. The ED Director typically scheduled at least one physician on duty 24 hours a day and one physician or mid level provider to work an overlapping 8–12 hour shift during the hours of peak patient volume. By early 2011, due to turnover, ED physician staffing was reduced to two full-time physicians, including the ED Director, and one 0.6 FTE physician. The ED relied on fee basis physicians to provide the remaining coverage, but in actuality there was an insufficient number to cover the hours required.

To provide coverage, the full-time physicians frequently worked over 80 clinical hours per pay period. In fact, during one 2-week pay period, a physician worked in excess of 160 hours. In addition, the ED Director reportedly performed his administrative duties between seeing patients. Even so, on nine occasions between January 2011 and June 2011, there was no second provider on duty during the hours of peak patient volume.

To address the staffing shortfalls, facility managers made questionable appointment decisions. First, they reappointed the fee basis physician for whom they had previously identified quality of care concerns in November 2010. Second, they assigned three primary care physicians to help cover the ED on a temporary basis. Two of the

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<sup>18</sup> VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010.

<sup>19</sup> VHA Directive 2010-010.

<sup>20</sup> System Memorandum No. 11C-6, *Emergency Department (ED) Standards of Operation*, March 1, 2009 (replaced on May 19, 2011).

physicians were granted clinical privileges for the ED on an emergent basis, but there is no record that the third physician was granted similar privileges.

### **Issue 3: Use of Diversion**

We substantiated that in early April 2011, the facility was on diversion overnight while two physicians were staffing the ED and inpatient beds were available. However, we were unable to identify any patients who were diverted to local hospitals.

VHA policy defines diversion as “the situation where any or all patients arriving by ambulance or referred from an outside VA or non-VA facility (who would normally be treated by the receiving facility) cannot be accepted because the appropriate care, services or beds are not available.” While in diversion status, facilities must continue to accept walk-in patients. In addition, a patient en route by ambulance may still request transport to the facility and receive care.<sup>21</sup>

The diversion referred to in the allegation occurred when two primary care physicians covered the ED. The documented reason for diversion was a lack of available inpatient beds; although, the facility bed census for that night showed that several appropriate inpatient beds were available. Our interviews with facility leadership indicated that the facility Director approved the diversion due to concerns that the physicians who were providing temporary coverage were unfamiliar with the ED and its operations. Although the documented reason for diversion was not accurate, we found no evidence that any patients were diverted. Therefore, we made no recommendation.

### **Review by VHA National Director for Emergency Medicine**

The deficiencies we identified during our review are indicative of broader management and oversight issues in the ED. Facility leaders acknowledged that they had concerns about the ED, and at their request, VHA’s National Director for Emergency Medicine conducted a site visit to review the ED in April 2011. The National Director identified 10 concerns related to physician staffing, compensation, scheduling, and utilization; support staffing; ED representation on key facility committees; leadership recognition of issues; and the physical plant. He made eight suggestions to address these concerns. In response, facility leaders developed an action plan, which included increasing fee basis physician pay, developing fast track procedures for low acuity patients, and establishing a contract with the facility’s university affiliate to provide ED physician coverage.

## **Conclusions**

We substantiated that two patients did not receive adequate evaluation and management in the ED, resulting in delayed treatment, but we did not substantiate quality of care concerns for a third patient. We found that facility managers had previously identified

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<sup>21</sup> VHA Directive 2009-069, *Medical Facility Emergency Department Diversion Policy*, December 16, 2009.

quality of care concerns with the physician who initially treated the three patients in the ED, yet they had not taken appropriate corrective actions in response to these concerns, as required by VHA policy. We also substantiated the allegation that the ED was understaffed since at least November 2010, resulting in questionable appointment decisions by facility managers, as well as quality of care concerns and an increased risk for excessive patient wait times in the ED. Lastly, we substantiated that the facility was on diversion over night while two physicians were staffing the ED and inpatient beds were available. However, we were unable to identify any patients who were diverted to local hospitals.

## Recommendations

**Recommendation 1.** We recommended that the interim facility Director consult with Regional Counsel regarding possible institutional disclosure to the families of the patients for whom quality of care concerns were identified.

**Recommendation 2.** We recommended that the interim facility Director consult with Regional Counsel regarding possible notification of quality of care concerns for a physician to the state licensing agency and/or National Practitioner Data Bank.<sup>22</sup>

**Recommendation 3.** We recommended that the interim facility Director implement procedures to ensure facility staff comply with VHA policies on peer review and physician privileging.

**Recommendation 4.** We recommended that the interim facility Director fully implement the May 2011 medical center policy addressing ED operations, specifically in regards to physician staffing and contingency planning.

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<sup>22</sup> The National Practitioner Data Bank is a national clearinghouse to collect information on disciplinary actions by a state licensing agency, hospitals, professional associations, or other entities against a health care practitioner.

## Comments

The VISN and Interim Facility Directors concurred with the findings and recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.

A handwritten signature in black ink, reading "John D. Daigh, Jr., M.D." in a cursive script.

JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General for  
Healthcare Inspections

## VISN Director Comments

**Department of  
Veterans Affairs**

### Memorandum

**Date:** December 2, 2011

**From:** Director, VA Health Care Upstate New York (10N2)

**Subject:** **Healthcare Inspection—Alleged Quality of Care and Staffing Issues, VA Western New York Healthcare System, Buffalo, New York**

**To:** Director, Bedford Office of Healthcare Inspections (54BN)

**Thru:** Director, Management Review Service (10A4A4)

Attached is Veterans Affairs Western New York Healthcare System (VAWNYHS), Buffalo, New York response to the Alleged Quality of Care and Staffing Issues. I have reviewed the draft report and Concur with all recommendations.

*(original signed by:)*

David J. West, FACHE

## Interim System Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** December 2, 2011

**From:** Interim Director, VA Western New York Healthcare System  
(528/00)

**Subject:** **Healthcare Inspection—Alleged Quality of Care and Staffing  
Issues, VA Western New York Healthcare System, Buffalo, New  
York**

**To:** Director, VA Health Care Upstate New York (10N2)

1. This is to acknowledge receipt and review of the draft alleged quality of care and staffing deficiencies report for Veterans Affairs Western New York Healthcare System (VAWNYHS).
2. Thank you for the opportunity to comment on the recommendations for improvement contained in this report. If you have any questions, please contact Kathryn Varkonda, VAWNYHS Performance Manager.

*(original signed by:)*

JASON C. PETTI, MSHA, VHA-CM  
Interim Director, VA Western New York Healthcare System  
(528/00)

## **Interim Director's Comments to Office of Inspector General's Report**

The following Interim Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

### **OIG Recommendations**

**Recommendation 1.** We recommended that the interim facility Director consult with Regional Counsel regarding possible institutional disclosure to the families of the patients for whom quality of care concerns were identified.

**Concur**

**Target Completion Date:** 12/31/11

#### **System's Response:**

The Acting Director, Chief of Staff, Chief of Performance Improvement met with Regional Counsel on November 16, 2011 regarding the possible need for an institutional disclosure to the families. Upon review of the policy, advice of Regional Counsel, medical record reviews and peer review findings it was concluded that the institutional disclosure as outlined in VHA Directive 2008-002 will be completed for patients 1 and 2.

**Status:** In process

**Recommendation 2.** We recommended that the interim facility Director consult with Regional Counsel regarding possible notification of quality of care concerns for a physician to the state licensing agency and/or National Practitioner Data Bank.

**Concur**

**Target Completion Date:** 11/30/11

#### **System's Response:**

The Acting Director, Chief of Staff and Chief of Performance Improvement met with Regional Counsel on November 16, 2011 regarding possible notification of quality of care concerns for the physician to the state licensing board or the National Practitioner Data Bank. Reporting to National Practitioner Data Bank would not be indicated in accordance with VHA Handbook 1100.17, "National Practitioner Data Bank Reports." The Acting Director, Chief of Staff and Acting Chief of Human Resources met



on November 25, 2011 related to possible reporting to the state licensing board. In accordance with VHA Handbook 1100.18, "Reporting and Responding to State Licensure Boards" and Medical Center Memorandum 05-17; a professional review of clinical practice was completed by the Chief of Staff and provided to the Acting Chief of Human Resources along with the focus reviews completed for the provider in question. The Acting Chief of Human Resources determined that the physician in question did not substantially fail to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients and therefore reporting to the state licensure board is not required.

**Status:** Completed

**Recommendation 3.** We recommended that the interim facility Director implement procedures to ensure facility staff comply with VHA policies on peer review and physician privileging.

**Concur**

**Target Completion Date:** 1/31/12

**System's Response:**

The current Medical Center Memorandum 11-35 "Peer Review for Quality Management" has been updated to follow the provisions of VHA Directive 2010-025, specifically, that actions initiated by supervisors of providers who receive a Peer Review with a final rating of Level 2 or 3 must be reported back to the Peer Review Committee the actions taken and the completion date. This information will be recorded in the minutes of the Peer Review Committee.

VA Western New York Healthcare System will review and comply with the Network 2 Policy regarding Privileging, 10N2-036-09 to comply with VHA Handbook 1100.19. The Chief of Staff has implemented compliance with FPPE/OPPE data with the Service Chiefs and the Credentialing and Privileging Coordinator. The process is discussed at the Credentialing and Privileging committee meetings.

**Status:** In process

**Recommendation 4.** We recommended that the interim facility Director fully implement the May 2011 medical center policy addressing ED operations, specifically in regards to physician staffing and contingency planning.

**Concur**

**Target Completion Date:** 1/31/12

**System's Response:**

The draft Medical Center Memorandum 11C-6,"Emergency Department (ED) Standards of Operations," was signed and distributed. The Medical Director of the ED will present a quarterly report to the Executive Committee of the Medical Staff detailing patient volumes, hourly visits and provider staffing patterns to track compliance. Each monthly schedule for ED providers will require the written approval of the Medical Director of the ED or his supervisor after ensuring that all staff have the required privileges.

**Status:** In Process

## OIG Contact and Staff Acknowledgments

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OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Jeanne Martin, PharmD, Project Leader Lynn Sweeney, MD, Team Leader Elaine Kahigian, RN, JD Monika Gottlieb, MD Claire McDonald, MPA

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## Report Distribution

### **VA Distribution**

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Interim Director, VA Western New York Healthcare System (528/00)

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